

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060 http://www.dail.vermont.gov

Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 30, 2017

Ms. Mary Jensen, Manager Wintergreen Residential Care Home 3 Union Street Brandon, VT 05733-1127

Dear Ms. Jensen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 21, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

amlaMCotaPN

Licensing Chief



	Division	of Licensing and Pro	, ntection			PRINTED: 03/01/20 FORM APPROVE
	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
-			0593	B. WING		C 02/21/2017
	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
	WINTER	GREEN RESIDENTIA	L CARE HOME 3 UNION	STREET N, VT 0573	4	
ŀ	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1	The state of the s	:
	PREFIX: TAG	(EACH DEFICIENC	Finust be precided by full SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ED-BISS COMMENT
	R100	Initial Comments:		R100		i 1
	13	was conducted by the Protection on 02/21 violations were identifications:	on-site complaint investigation the Division of Licensing and /2017. State regulatory stiffed and the specifics are as		The action tak correct this do was terminatin	Fisiency
!	R127 SS=G	V. RESIDENT CAR	E AND HOME SERVICES	R127	two employees	Jinuo lued
		resident's dignity an accomplishments a encouraged to parti- daily living. Families	nd abilities. Residents shall be cipate in their own activities of shall be encouraged to		with the incide will also continued current future employ	vets Handau ees Obbut
	1,	their ability and inter of the resident.	nd care planning according to rest and with the permission This not met as evidenced	,	providing caré residents and a their dignity.	
	7	by: Based on medical re and staff interviews, failed to assure that	ecord review, observations the community care home 1 of 3 sampled residents was espected the resident's		The measures place, sothis recur are, at	doesnit
		Resident # 1 was ad home on 06/07/2014 standing right calf ul- history of a heart atta further indicates that the home on 2/7/201 tospitalization for a status. On the mom- nome health arrived,	review on 2/21/2017, mitted to the community care with impalred cognition, long cer, atrial fibrillation and ack. The medical record Resident # 1 had returned to 7 following a 2/3/2017 decline in his/ her overalling of 2/3/2017, a nurse from as scheduled, to change		shift change be employees are - each resident to for re-assurent	to Check together e of nady.
W 15. TO	ISION OF LICE SORATORY I	ensing and Protection DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	17	Owner Ma	(X8) DATE
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R127-R224 POC accepted 3/30/17 GCOLEMANEN/ FINE

AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY
				N	COLUMN DESCRIPTION
			A. BUILDING):	COMPLETED
		0593	B, WING		C
	PROVIDER OR SUPPLIER			**************************************	02/21/2017
WINTER				STATE, ZIP CODE	
	RGREEN RESIDENTIA		I STREET ON, VT 0573:	ኅ	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1	 	
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R127	Continued From pa	age 1	R127		
	the dressing on Re	esident # 1 leg and found him/	1. D-f-4	- before -	101-1-1-0-1-27
	ner slumped over i	n a chair, having been	- S	it is a second of the second	reave
	incontinent of stool	 Staff reported that they were 		start the n	ext Shitt
	unable to stand Re him/ her and so "w	esident # 1 in order to clean iped up around as best they	tha	+ an reside	2000 000
1	could." Staff repor	t that this was noticed during	10100		and mt
	rounds at 3:00 am and that no one was notified to come to assist the staff member on duty. Resident # 1 was left in this condition until the home health nurse arrived at 11:00 am. Administration reports that at the change of shift when more personnel are available. Resident # 1		i Vea	n and safe	. It help
			Hw.H	h aresiden	
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			Oct 2	shift chang	a thousand
			LA "	ST019 - 1001 10	e meg are
	was not cleaned an	id or moved into bed.		Stay unitil	the Situat
1	On 2/8/2017 Resident # 1 was seen in the hospital emergency room for elevated blood		1150	u taken ca	of
			11-00	in well we	re ot,
	pressures, as taker	by the staff at the home			NATA
	returned to the hor	I in the emergency room and se until 2/17/2017 when s/he	Cerry	rective meas	11/11 200 V
}	Was brought back to	o the hospital	1000	D 1 de	$\frac{1}{2}$
	There are no asses	sments done at this time to		nonitored a	aily MA
	indicate a change in	the condition of Resident # 1	Ithe	manager.	()
	of the community ca	s were exceeding the abilities are home.			words that the transfer of the control of the contr
			Corre	ective action	will be
R136	V. RESIDENT CAR	E AND HOME SERVICES (R136	om pleted by	13/1/17
SS=D				on picker p	9 9/1/11
!	5.7. Assessment		M		
	F 77 - F		•		
	ರ.7.೮ tach resident annually and at anv	shall also be reassessed point in which there is a			
(change in the reside	nt's physical or mental			
(condition.	1\2 \chi montal			
i !					•
.)					
;]	This REQUIREMEN	T is not met as evidenced	,		
on of Lice	nsing and Protection				

Division of Licensing and Protection					
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0593	B. WING		C 02/21/2017
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY,	STATE, ZIP CODE	1 September 11 Sep
WINTER	GREEN RESIDENTIAI	CARE HOME 3 UNION	STREET N, VT 0573;		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE
,R136	Continued From pa	ge 2	R136		
	by: Based on medical rinterviews, the comassure that 1 of 3 reassessed after a chastatus. (Resident # details: Per medical record Resident # 1 was achome on 06/07/201 standing right calf uhistory of a heart attended further indicates that the home on 2/7/20 hospitalization for a status. On the morn home health arrived the dressing on Resher slumped over in incontinent of stool, unable to stand Reshim/ her and so "wip could." Staff report rounds at 3:00 am a come to assist the s Resident # 1 was left home health nurse a Administration report when more personnity was not cleaned and this Resident # 1 was walker. There are no assessindicate a change in	ecord review and staff munity care home failed to esidents was properly lange in his/ her physical 1). See below for specific review on 2/21/2017, dmitted to the community care 4 with impaired cognition, long loer, atrial fibrillation and tack. The medical record tt Resident # 1 had returned to 17 following a 2/3/2017 decline in his/ her overall ning-of 2/3/2017, a nurse from , as scheduled, to change ident # 1 leg and found him/ a chair, having been Staff reported that they were ident # 1 in order to clean led up around as best they that this was noticed during and that no one was notified to taff member on duty. It in this condition until the	THARBY THAT PROBLEM TO THE	action taken a deficiency assessment the that that their status measures the into place so recur are, a ed at the RI ssess if characters a resident aspilized. Corrective be monitor to anager a KS, and as	ris to update As including A has had nemal change s. not will be othis does reminder No dest to nges occur or a resider measures pred by every 2 needed.
	interview that there v	nd director confirm during vere no assessments to	Corr	ective actio	3/1/17
Vision of Lic. FATE FORM	ensing and Protection			DIA SAM	•

Division	of Licensing and Pr	otection			FORM APPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
		0593	B. WING_		C 02/21/2017
NAME OF	PROVIDËR OR SUPPLIËR	STREETAL	DDRESS, CITY.	STATE, ZIP CODE	1 02/21/2017
WINTER	GREEN RESIDENTIA	L CARE HOME 3 UNION	STREET N, VT 0573		,
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R136	Continued From pa	age 3	R136	•	
	indicate a change i Resident # 1.	in the physical status of			
R147 SS≂E	V. RESIDENT CAF	RE AND HOME SERVICES	R147	The action tak	en to
	5.9.c (4)			correct this d is the RN rev	iewed -
	physician of all resistant include: reside medication ordered administration; and This REQUIREMENT by: Based on medical reside of a sampled reside of 3 sampled reside of 3. The specifics and Per record review of there are no parameters of a sampled review of the specifics of the specific of	f Residents # 1, # 2 and # 3, eters listed on which se for pain relief. All have read: 2 by mouth every 6 hours as ever; g by mouth every 6 hours as lenol 2 tabs every 4 hours for ort/ malaise		the residents in records and so guidelines for to ensure who medication to 1. The measures of Place So this director again is will have more with the R.N. of with the R.N. of corrective machine to ensure the depractice does not practice does not a practice does not	the P.C.A ich Pain use. Put into cosnit the P.C.A e training and the parameter inalgesics. ons will y the R.N.
	∍ttendants to give m Juidelines for them t	program is for personal care edications but there are no o know which pain e. The home's nurse		Corrective action be completed by	3/1/17

Division	of Licensing and Pr	otection			FORM	APPROVE
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	- LIVAL DATE	SURVEY
AND LIST	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:			E SURVEY PLETED
		0593	B. WING			C 21/2017
NAME OF	PROVIDER OR SUPPLIER	STREET	UDDBESS CITY (STATE, ZIP CODE	1 021	21/2017
VAUNTED	CREEN DEGINERATION		STREET	STATE, ZIP CODE		
AADALEK	GREEN RESIDENTIA	E CANE INDIC	ON, VT 05733			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRE		
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		, and an entire the	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
R147	Continued From pa	ine A			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>
		"	R147			
	PM.	j a telephone interview at 1:30)			
		•				
R189	V RESIDENT CAR	E AND HOME SERVICES				
S\$≒D	THE SIBLING OAK	L AND FIGURE SERVICES	R189			
ļ			I the	action taken to	s couls	Ct-
	5.12,b. (3)		this o	deficiency is the	2.RN	
	For residents requir	ing nursing care, including		ted the assess.		- 00
	nursing overview or	medication management the				
}	ręcora snali also co.	ntain: initial assessment:	INCOLL	ent #1 for as	91111	CONT"
.	annual reassessme	nt; significant change	Chang	e in physical st	-X+US,	
	assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed			<u> </u>	•	
			the	neasures put	into	Place
				ried score 3 Par	من از از ما حساس	,
	and resident plan of	d treatment documentation;	120 4	nis doesn't rea	Jul 13	\geq_{I+}
	and resident high fil	care.	the 1	2N will commu	unicate	e with
	This REQUIREMEN	T is not met as evidenced	PCA	weekly in refe	oron(e	Or
	by: Based on medical m	cord review and staff	l was i	ents changes	ANDIOCI	NO DE
1	interviews, the comp	nunity care home failed to	1,621cm	into changes	2017 CT C	JUI K
	nave an updated ass	sessment after a significant		? continues to		
1	change in physical s	tatus for 1 of 3 residents in	resid	ents charts on	. Curre	い た
1,	are sample. (Reside) detailed below	nt # 1). The specifics are	Phisi	s introm & la	7+C+115	. .
}	TTIMIOU DUICIN,	•	6.00	cal & mental S	71001000 1 2 6 100	inh
[]	Per medical record re	eview on 2/21/2017,	KIN, O	ontinges to rea		
ļ <u>ļ</u>	Kesident # 1 was adi	mitted to the community care	Nova	s to Stay upda	467 OL	LCERK
] ;	Standing right calf uto	with impaired cognition, long er, atrial fibrillation and	reside	MS STOCKUS.		
1	nistory of a heart atta	ck. The medical record				V,
1	urtner indicates that	Resident # 1 had returned to !		tive actions w		
	ne nome on 2///201	7 following a 2/3/2017	MACADIN	fored weekly f	ou the	. R.N
f	nospitalization for a d status	lecline in his/ her overall	1110111	<u> </u>	٠	
		; ;	Conces	tive actions wi	11 60	
(On 2/8/2017 Residen	t#1 was seen in the		pleted by 3/1/	, <u></u>	
ision of Lice	nsing and Protection		W (M	DIEMA DA OITI	[']	

in of Licensing and Pro	otection		FORM APPROVED
ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	0593	B. WING	C 02/21/2017
F PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	
RGREEN RESIDENTIA	L CARE HOME 3 UNIO	N STREET	
: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCE	TON SHOULD BE COMPLETE THE APPROPRIATE DATE
9 Continued From pa	ge 5	R189 —	
pressures, as taken S/he-was evaluated returned to the home was brought back to The last assessment dated 6/1/2016 through There are no assess hospitalization or up to indicate a change # 1. The home's nu confirm, during interare documented as	by the staff at the home. in the emergency room and e until 2/17/2017 when s/he the hospital. It for Choices for Care is ugh 5/31/2017, sments done prior to on his/ her return to the home in the condition of Resident rse and director both view, that no assessments having been done after a		
overall status.	* *	R207	
5.18.b The licensee report suspected or ineglect or exploitation staffs responsibility transitional incident did occur or of the licensing agent conduct its own investing of incident to Adult Protestal Requirement to	and staff are required to reported incidents of abuse, in. It is not the licensee's or o determine if the alleged not; that is the responsibility by Ahome may, and should, stigation. However, that must the alleged or suspected ective Services. Is not met as evidenced cord review, staff interviews by sinvestigation, the efailed to report a	this deficiency is the A.P.S. phone call when there of Suspision or Their ing for (future employ with more con between RN, m in reference to Over all Coure	s RN posted 2 humber to 3 an incident alleged. Eurrent & Jees, along imunication Anagers, staff residents. and health.
	F PROVIDER OR SUPPLIER RGREEN RESIDENTIAL SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa hospital emergency pressures, as taken S/he-was evaluated returned to the hom was brought back to The last assessmer dated 6/1/2016 throi There are no assess hospitalization or up to indicate a change # 1. The home's nu confirm, during inter are documented as significant change in overall status. V. RESIDENT CARE 5.18 Reporting of At 5.18 Reporting of At 5.18 Reporting of At incident did occur or neglect or exploitatio staff's responsibility t incident did occur or of the licensing agen conduct its own inves not delay reporting of incident to Adult Prote This REQUIREMENT by: Based on medical rec and the internal home community care home suspected incident of	ENT OF DEFICIENCIES IN OF CORRECTION O593 F PROVIDER OR SUPPLIER RGREEN RESIDENTIAL CARE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 hospital emergency room for elevated blood pressures, as taken by the staff at the home. S/he-was evaluated in the emergency room and returned to the home until 2/17/2017 when s/he was brought back to the hospital. The last assessment for Choices for Care is dated 6/1/2016 through 5/31/2017. There are no assessments done prior to hospitalization or upon his/ her return to the home to indicate a change in the condition of Resident # 1. The home's nurse and director both confirm, during interview, that no assessments are documented as having been done after a significant change in his/ her and decline in overall status. V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation or export suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not, that is the responsibility of the licensing agency. A horne may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced	ENT OF DEFICIENCES IN DECORRECTION OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3 UNION STREET BRANDON, VT 05733 SUMMARY STATEMENT OF DEFICIENCIES [EACH DEPTICIENCY MUST BE PRECEIVED BY PULL REGULATORY ON LAS DEPTITYING INFORMATION) PREPRIX CONTINUED From page 5 Continued From page 5 Assigned a change in the emergency room and returned to the home until 21/7/2017 when s/he was brought back to the hospital. The last assessment for Choices for Care is dated 8/4/2016 through 5/31/2017. There are no assessments done prior to hospitalization or upon his/ her return to the home to indicate a change in the condition of Resident #1. The home's nurse and director both confirm, during interview, that no assessments are documented as having been done after a significant change in his/ her and decline in overall status. V. RESIDENT CARE AND HOME SERVICES 5.18. Reporting of Abuse, Neglect or Exploitation to 15. The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the ilcensee's or staff's responsibility to determine if the alleged incident (ad occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and the internal home's investigation, the community care home failed to report a suspected incident of neglect for 1 of 3 residents. The MCQSULES Home and Construction of the decident of neglect for 1 of 3 residents. The MCQSULES Home and MCQSULES

Division	of Licensing and Pro	tection	•	FORM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
		0593	B. WING	02/21/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZIP CODE	
WINTER	GREEN RESIDENTIA	BRANDO	STREET ON, VT 05733	
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT AG CROSS-REFERENCED TO THE APPROPRIES.)	JLD BE COMPLETE
R207	Continued From pa	ge 6	R207	
	(Resident # 1.) The	specifics are detailed below:	Place are more	SURVEYS
R224 SS=G	Per staff interview of to notify the regulate physician of an epis Resident # 1. The interview, that they by the home health Protective services needed to be done not make any notific uncleaned for over VI. RESIDENTS' RI	on 2/21/2017, the home failed by agency or the resident's code of suspected neglect for home staff report, during thought that the report made nurse to APS (Adult was all the reporting that). They confirm that they did eations about a resident left 8 hours. GHTS Shall be free from mental, ouse, neglect, and nts shall also be free from	training about a be or is neglect. Or exploitation. S immedicately Call if they are unsur Corrective action R224 be monitored by doily along with new employees to packet.	noth can abuse tarff will RN, Manage e. ns will manager all
	This REQUIREMENty; Based on medical reinterviews, the commassure that 1 of 3 reinterviews, the commassure that 1 of 3 reinterviews, the commassure that 1 of 3 reinterviews, the commassure that 1 was added to 100/07/2014 standing right calf ultiple indicates that the home on 2/7/2014 hospitalization for a costatus. On the morning that the commassure in the morning that the commassure in the morning that the commassure in the morning that is the commassure in the morning that is the commassure in the commassure i	T is not met as evidenced ecord review and staff nunity care home failed to sidents was free from the specifics are	Corrective action will be completed 3-1-17	is by-
ision of Lice	ensing and Protection			

vision	vision of Licensing and Protection						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED		
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ME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODÉ			
INTERGREEN RESIDENTIAL CARE HOME 3 UNION S BRANDON				3			
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DE CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE		
R224	the dressing on Reher slumped over incontinent of stoo unable to stand Rehim/ her and so "would." Staff reporrounds at 3:00 am come to assist the Resident # 1 was home health nurse Administration repowhen more person was not cleaned ar This was confirmed	d, as scheduled, to change sident # 1 leg and found him/ n a chair, having been. Staff-reported that they were sident # 1 in order to clean iped up around as best they that this was noticed during and that no one was notified to staff member on duty. eft in this condition until the arrived at 11:00 am. orts that at the change of shift nel are available, Resident # 1 nd or moved into bed. I by the Director of the home the afternoon and by	R224	the action tar correct this de- is an storff an are to continue residents every Check each rest change to ensur are clean, dry s starf signs of starf signs	ficiency el all shifts e to check hour and dent at shift re residents from a sheet idents are lidents are to story and		
				the measures place are two employs checking on all before the ne starts so there for any resident the manager wand monitor if the are being comp corrective actions	yees are i residents et shift e's no excuse being neglected the checks leted daily.		
1 of Lice	ensing and Protection			be completed	by 3-1-17		
FORM		56	199 £	B11M1	Manual Company		